# Medi-Cal

## Focus: Managed Care

*Moving toward a shared future*

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### TWO-PLAN MODEL MANAGED CARE OVERVIEW

Since January 1996, the Department of Health Services (DHS) began implementing the Medi-Cal Two-Plan Model managed care program. Contractors now provide or are preparing to provide Medi-Cal services under the Two-Plan Model in 12 counties: San Francisco, Alameda, Contra Costa, Santa Clara, Stanislaus, San Joaquin, Fresno, Tulare, Kern, Los Angeles, San Bernardino and Riverside. In each county, DHS contracted with two managed care plans to render Medi-Cal services—one a commercial health plan and the other a local initiative (a publicly sponsored health plan cooperatively developed by local government, clinics, hospitals, physicians and other providers historically serving the Medi-Cal population). Fresno county is an exception with two commercial plans and no local initiative plan.

Medi-Cal services not covered by health plans will continue to be available through the Medi-Cal Fee-for-Service (FFS) program. Existing Medi-Cal contracts with Prepaid Health Plans (PHP) and Primary Care Case Management (PCCM) plans will be discontinued once the Two-Plan Model begins operation in each county. However, many existing PHP and PCCM contractors are affiliated with a commercial plan or local initiative and will continue to render services as subcontractors. Under these circumstances, beneficiaries may be able to continue their established relationships with an existing PHP or PCCM. Special Projects will continue to provide services to enrollees in counties where the Two-Plan Model is implemented. Examples of "special projects" are On Lok, Senior Citizens Action Network (SCAN), Center for Elders Independence, AIDS Health Care Foundation and The Family Mosaic Project.

***Medi-Cal*** **is published quarterly by the California Department of Health Services, Medi-Cal Payment Systems Division, to inform Fee-for-Service Medi-Cal Providers about current trends impacting the Medi-Cal program. Our focus for the first series of issues will be Managed Care.**

### ELIGIBILITY

Enrollment in one of the Two-Plan Model managed care plans is mandatory for Medi-Cal beneficiaries who reside in one of the 12 counties, are not required to pay a Share of Cost, and have a "mandatory" aid code *(see Two-Plan Model Eligible Aid Codes, page 2)*.

### THIS MONTH

## ELIGIBILITY *(CONTINUED)*

Beneficiaries required to enroll are allowed to select a participating plan. If selection is not made in a specified time frame, the beneficiary is automatically assigned to a plan (default assignment). Medi-Cal beneficiaries who have a "voluntary" aid code may choose to enroll in one of the Two-Plan Model managed care plans or remain in the FFS program.

Some beneficiaries with a mandatory aid code may qualify for an "exemption" and thus receive health care services through the FFS program. Enrollment packages contain additional information regarding this exemption. Those persons who may be eligible for exemption are:

- Native Americans, their household members and other people who qualify for services from an Indian health clinic
- Beneficiaries with a complex or high-risk medical condition who are in an established treatment relationship with a provider(s) not affiliated with either plan
- Beneficiaries who are pregnant and under the care of participating Medi-Cal physicians not contracted with either plan
- Beneficiaries who have tested HIV positive or have been diagnosed with AIDS
- Beneficiaries participating in pilot projects, including "special projects"
- Children under California Children Services (CCS) who receive services from a primary care provider integral to the child's CCS treatment plan, and the provider is not contracted with either plan
- Children in foster care or the Adoptions Assistance Program

**TWO-PLAN MODEL**

**ELIGIBLE AID CODES**

**Mandatory Enrollment:**

01, 0A, 02, 08, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3G, 3H, 3P, 3R, 45, 54, 59, 82

**Voluntary Enrollment**:

03, 04, 4C, 4K, 5K, 6A, 6C, 10, 14, 16, 18, 20, 24, 26, 28, 36, 40, 42, 60, 64, 66, 68, 86

## STATUS IN LOS ANGELES COUNTY

The two health plans available in Los Angeles county are L.A. Care Health Plan (operational April 1, 1997)—a local initiative plan—and Foundation Health (operational July 1, 1997)—a commercial plan. L.A. Care Health Plan's provider network includes seven plan partners: Blue Cross of California, Care 1st Health Plan, Community Health Plan, Kaiser Permanente, Maxicare, Tower Health and United Health Plan. L.A. Care network includes 2,600 primary care physicians and approximately 3,600 specialists. Kaiser Permanente is not accepting any new Medi-Cal beneficiaries at this time because it has reached its full operating capacity.

Foundation Health has two subcontracted health plans: Molina Medical Centers and Universal Health Plan. The combined Foundation Health network includes approximately 2,000 primary care physicians and approximately 6,500 specialists. Foundation Health continues to provide services to beneficiaries served while previously under contract as a PHP.

## STATUS IN LOS ANGELES COUNTY *(CONTINUED)*

In L.A. county, the default process is temporarily on hold. Medi-Cal beneficiaries with a mandatory aid code in L.A. county may continue to receive health care services through the FFS system or enroll in one of the health plans under the Two-Plan Model. The default assignment is expected to begin January 1, 1998, when FFS will no longer be a choice for Medi-Cal beneficiaries who have mandatory aid codes.

## ENROLLMENT

Medi-Cal beneficiaries eligible to enroll in one of the plans receive a packet of information that includes an enrollment form and written notice of the requirement to select one of the two available managed care plans. When the beneficiary completes the enrollment form, he/she can expect enrollment into the health plan to be effective within 15 to 45 days from the date the Health Care Options enrollment contractor receives the enrollment form for processing. All Medi-Cal beneficiaries receive a Benefits Identification Card (BIC). Additionally, health plans provide members with their own health plan card which usually identifies the member's primary care physician along with a 24-hour toll-free number. In most cases, the Medi-Cal beneficiaries will present both cards when receiving services.

***Medi-Cal providers may wish to assess the impact that Medi-Cal managed care will have on their respective Medi-Cal patient caseloads.***

If beneficiaries are dissatisfied with their health plan or need an enrollment/disenrollment package, they may call MAXIMUS (the enrollment contractor) toll-free at 1-800-430-4263, weekdays from 8:00 a.m. - 5:00 p.m. It is important to note that beneficiaries do not need to submit a disenrollment form to change primary care providers—they need only contact the plan's Member Services Department.

Medi-Cal providers may wish to assess the impact that Medi-Cal managed care will have on their respective Medi-Cal patient caseloads. Medi-Cal providers can evaluate their current patient caseloads to determine the number of their active patients who are in mandatory aid code categories and those who are in voluntary aid code categories. Whether a provider is affiliated with a health plan or exclusively FFS, it is acceptable for providers to inform their patients of their current availability status and patients may wish to consider their options if they wish to continue to be seen by their provider.

## *for information...*

**L. A. CARE HEALTH PLAN**

| | |
|---|---|
| Provider Services | (213) 437-7200 |
| Claim/Billing Disputes | (213) 437-7200 |
| Member Services | (888) 452-2273 |

**FOUNDATION HEALTH PLAN**

| | |
|---|---|
| Provider Services | (818) 683-6325 |
| Provider Inquiry | (800) 634-7148 |
| Claim/Billing Disputes | (800) 675-6110 |
| Member Services | (800) 675-6110 |

**ELECTRONIC DATA SYSTEMS**

| | |
|---|---|
| **Provider Support Center** | (800) 541-5555 |
| Beneficiary Telephone & Correspondence | (916) 636-1980 |
| Point of Service Help Desk | (916) 636-1990 |
| Computer Media Claims Help Desk | (916) 636-1100 |

**DEPARTMENT OF HEALTH SERVICES**

**Managed Care Division**

| | |
|---|---|
| Managed Care | (916) 654-8076 |
| Ombudsman | (888) 452-8609 |

**Payment Systems Division**

| | |
|---|---|
| Provider Enrollment Unit | (916) 323-1945 |
| Health Care Options Enrollment Contractor (MAXIMUS) | (800) 430-4263 |

## QUESTIONS & ANSWERS

*How do I become a managed care provider?*

To become a managed care provider in the Two-Plan Model in L.A. county, you must contact Foundation Health and/or L.A. Care Health Plan. L.A. Care Health Plan may be reached at (213) 437-7200; Foundation Health may be reached at (818) 683-6325.

*If I affiliate with a plan, will I receive the same reimbursement I am receiving under Fee-for-Service?*

Provider reimbursement rates are subject to subcontract negotiation between the health plan and the provider.

*If I am not getting paid, who do I call?*

Claims are processed by participating Plan Partners, Individual Practice Association (IPA)/Medical Group or Management Services Organization (MSO), as provided for in respective contracts. Disputes regarding claims, which are not resolved at the Plan Partners/IPA/Medical Group/MSO level, may be directed to L.A. Care or Foundation Health for resolution. If necessary, contact an L.A. Care Representative at (213) 437-7200 or an Foundation Health Representative at 1-800-675-6110.

***Do you have a specific question regarding managed care that you would like to see answered in a future issue?***

***Please write to:***

**Department of Health Services**
**Medi-Cal Payment Systems Division**
**Provider Services Section**
**Medi-Cal Newsletter**
**714 P Street, Room 950**
**P.O. Box 942732**
**Sacramento, California 94234-7320**

## EXCLUDED (CARVE OUT) SERVICES

Medi-Cal beneficiaries enrolled in a two-plan model managed care plan obtain most of their benefits from their health plan. Medi-Cal services not covered by the plan are referred to as "excluded" or "carve out." These services can only be rendered by a Medi-Cal-enrolled provider and must be billed through the Medi-Cal FFS system. In most cases, beneficiaries remain enrolled in their health plan while also receiving these services. The panel below lists those excluded services that may be obtained while a beneficiary remains enrolled in a managed care plan:

**EXCLUDED SERVICES**

*(Member remains enrolled in Managed Care and receives services through the FFS system)*

- Acupuncture Services
- Adult Day Health Care Services
- Alcohol and Drug Treatment Services
- California Children Services
- Childhood Lead Poisoning Case Management
- Chiropractic Service
- Dental Services
- Department of Development Services Administered Medicaid Home and Community Based Services Waiver
- Directly Observed Therapy for Treatment of Tuberculosis
- Fabrication of Optical Lenses
- Healing by Prayer or Spiritual Means Services
- Lab Services under State Alphafetoprotein Testing Program
- Local Education Agency Assessment Services & Other Specified LEA Services
- Outpatient Heroin Detoxification
- Short-Doyle Medi-Cal Mental Health Programs
- Specialty Mental Health Services (Inpatient & Outpatient)
- Specified Psychiatric and HIV/AIDS Drugs, effective July 1, 1997
- Targeted Case Management

A few excluded services require that the beneficiary be disenrolled from the managed care plan in order to receive these services. The health plans are responsible for initiating disenrollment and ensuring an orderly transfer to the Medi-Cal FFS program. The panel below lists these excluded services for which the beneficiary must be disenrolled from the plan:

**EXCLUDED SERVICES**

*(Member disenrolls from Managed Care)*

- AIDS Waiver Program
- In-Home Medical Care Waiver Program
- Long Term Care (approximately 60 days after admission)
- Major Organ Transplantation
- Model Waiver Program
- Multi-purpose Senior Services Waiver Program
- Skilled Nursing Facility Waiver Program